PART B: Improvement Targets and Initiatives 2012/13

Riverside Health Care Facilities 110 Victoria Ave. Fort Frances, Ontario P9A 2B7

AIM		MEASURE					CHANGE			
Quality dimension	Objective	Measure/Indicator	Current performance	Target for 2012/13	Target justification	Priority level	Planned improvement initiatives (Change Ideas)	Methods and process measures	Goal for change ideas (2012/13)	Comments
Safety	Reduce clostridium difficile associated diseases (CDI)	**CDI rate per 1,000 patient days**: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2011, consistent with publicly reportable patient safety data	N/A	N/A						
	Reduce incidence of Ventilator Associated Pnemonia (VAP)	**VAP rate per 1,000 ventilator days**: the total number of newly diagnosed VAP cases in the ICU after at least 48 hours of mechanical ventilation, divided by the number of ventilator days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2011, consistent with publicly reportable patient safety data	N/A	N/A						
	Improve provider hand hygiene compliance	**Hand hygiene compliance before patient contact**: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - Jan-Dec. 2011, consistent with publicly reportable patient safety data	81.30%	84.30%	Improve current performance. Higher than provincial average of 72.14%	1	1) Staff participation in Hand Hygiene training module	Percentage of staff completing OHA online Hand Hygiene module	100% of all staff participate in Hand Hygiene education	Current Performance is average of Q 1 & Q2, Q3 results skewed due to poor sample size N=10
							2) Recognition of National STOP! Clean Your Hands Day - May 7, 2012	Track newsletter submission and distribution of promotional material to all sites	Newsletter submission for first week of May to entire Corporation	
							3) Audit Hand Sanitizer stations	All Sanitizer stations to be filled	100% of Hand Sanitizer stations filled	
	Reduce rate of central line blood stream infections	**Rate of central line blood stream infections per 1,000 central line days**: total number of newly diagnosed CLI cases in the ICU after at least 48 hours of being placed on a central line, divided by the number of central line days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2011, consistent with publicly reportable patient safety data	N/A	N/A						
	Reduce incidence of new pressure ulcers	**Pressure Ulcers**: Percent of complex continuing care residents with new pressure ulcer in the last three months (stage 2 or higher) - FY 2010/11, CCRS	N/A	N/A						
	Avoid patient falls	**Falls**: Percent of complex continuing care residents who fell in the last 30 days - FY 2010/11, CCRS	N/A	N/A						
	Reduce use of physical restraints	**Physical Restraints:** The number of patients who are physically restrained at least once in the 3 days prior to initial assessment divided by all cases with a full admission assessment - Q4 FY 2009/10 - Q3 FY 2010/11, OMHRS	N/A	N/A						
	Reduce Medication Errors	**Medication Reconciliation:** Percentage of patients for whom Medication Reconciliation was completed on admission	70%	75%	Improve current performance	2	1) Ongoing education for registered staff	Attendance at education sessions	100% compliance	
							2) Continuous communications regarding Medication Reconciliation	Monthly newsletter submissions highlighting Medication Reconciliation	Monthly	
							3) Medication Reconciliation incorporated into nursing orientation	Completion of module at orientation	100% Nursing staff completed module	
							4) Improve compliance with Medication Reconciliation completion	Monthly audits and follow up	100% of audits followed up	
	Reduce patient/resident falls	**Falls Reduction:** Reduce the number of level 3 & 4 falls for the organization. Acute & LTC combined. Q4 FY 2010/11 - Q3 FY 2011/12	19	18	No industry standard for fall reduction targets. Rate proposed by BC Injury Research and Prevention Unit, 5% reduction	2	1) Falls risk assessments will be done on all patients/residents within 24 hours of admission	Spot audits of all patient/resident charts to ensure complete risk assessment	100% of all patient/residents assessed for falls risk within 24 hours of admission	Baseline will identify procedure/training needs and provide guidance for improvement target for 2013/14
							2) Interventions to be standardized in all facilities based on risk level	Review care plans to determine what applicable interventions have been implemented	Determine baseline of % of applicable interventions included in care plans	
Effectiveness	Reduce unnecessary deaths in hospitals	**HSMR:** number of observed deaths/number of expected deaths x 100 - FY 2010/11, as of December 2011, CIHI	N/A	N/A						
	Improve organizational financial health	**Total Margin (consolidated):** Percent by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year. Q3 2011/12, OHRS	0.78%	0	Balanced budget	1	1) Regional Supply Chain and Pooled Benefit Initiatives	1) Measure year over year savings from implementation of initiatives	Maintain balanced fiscal position for 12/13 operating year in light of 0% revenue increase assumption	Actual based on 11/12 Q3 data
	Current Ratio	**Current Ratio:** Current assets divided by current liabilities	1.5	1.32	Balanced budget	3	Refer to Total Margin	Refer to Total Margin	Maintain performance under H-SAA reporting within Corridor and achieve target	Actual based on 11/12 Q3 data
	Inventory Turnover	**Number of days held:** Q2 2011/12	22 days	20 days	9% reduction	3	1) Improve Inventory Turnover (days held) to increase operational efficiency	1) Monitor indicator on a quarterly basis	Reduce Inventory Turnover (Days Held) to Target established	Actual based on 11/12 Q2 data
								2) Evaluate items with long "days held"		
								3) Identify and implement JIT supply chain practices where feasible		
	Capital Requests Processed	**Percent of approved capital equipment:** Purchases made in quarter planned	N/A	100%	Theoretical best	1	To attain 100% compliance for capital purchases within the planned or budgeted quarter	Monitor actual vs. budget on a quarterly basis and address performance gaps	Achieve 100% compliance	No prior year benchmark available
	Strategic Plan	**Strategic Plan Implementation:** Achievement of all process measures required for initiation of formal strategic planning.	N/A	100%	A comprehensive and well-laid Strategic Plan is necessary to drive the	1	1) Conduct an environmental scan to gain and use information about trends and relationships both within and outside the organization.	1) Complete environment scan	Development of Strategic Plan, including environmental scan, completion of strategic planning	

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					organization forward over the next several years		2) To advance teamwork, communication and cross-functional work with the organization	2) Engage Management/Senior Management in Team Development exercise(s)	document, distribution to stakeholders, timelines established and leads assigned	
							3) Conduct a strategic planning process with input from staff, Board of Directors and community partners	3) By the end of Q3 Strategic planning sessions will be scheduled		
							4) Share plan with stakeholders and communities	4) By the end of Q4, plan will be shared with stakeholders and communities. Timelines will be established and Leads will be assigned		
							5) Assign leads and timelines			
	Reduction in sick time hours	Data validity is being determined	TBD	TBD		TBD				Will introduce to 12/13 QIP at a later date
Access	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Admitted patients. Q3 2011/12, NACRS, CIHI	N/A	N/A						
	Length of stay in ED	**Average length of stay for Emergency Patients:** Current performance is average for 2011	1.9 hrs	1.9 hrs	Maintain or reduce time, provincial average 4.3 hrs	3	1) Implement an ED adhoc Committee to review	1) Develop a report that can be used for tracking progress	1) Develop a policy with respect to Observation Patients with reassessment after 12 hours followed by an order to admit or discharge	
							2) Develop a strategy to reduce the average length of stay for Emergency visits	2) Review and evaluate clinical/statistical data to identify possible areas for improvement	2) Where possible implement recommendations from review and evaluation of clinical/statistical data	
							3) Develop a monitoring process	3) Develop report to identify ED visits with length of stay greater than or equal to the 75th percentile		
							4) Review visits where length of stay was greater than or equal to 6.5 hrs (75th percentile)			
	Reduce the number of Triage Level 4 and 5 patients seen in Emergency/Urgent Care Departments	**Number of Level 4 & 5 patient visits:** Number of triage level 4 (less urgent) and level 5 (Non urgent) patients seen in our Emergency/Urgent Care Departments as a percentage of the total number of patients seen	53%	43%	To ensure that patients are being seen in the most appropriate care setting within the community and that triage levels are assigned in accordance with CTAS guidelines	1	1) Implement an ED/Urgent Care Adhoc Committee to review	1) Develop a report that can be used for monitoring progress	1) To reduce wait times in the Emergency/Urgent Care Department and improve patient flow	
							2) Develop a strategy to reduce the number of triage level 4 and level 5 patients.	2) Review and evaluate clinical/statistical data to identify possible areas for improvement	2) To confirm that triage levels are being assigned in accordance with CTAS guidelines	
							3) Develop and implement a monitoring process			
							4) Perform an audit on triage practices to ensure triage levels are being assigned in accordance with CTAS guidelines			
	Improve documentation of Physician Assessment date/time in Emergency	**Physician Assessment**: Percentage of Emergency visits where physician assessment time was documented. Current performance year end 2011	73%	80%	Improve current performance	3	1) Implement an ER Adhoc Committee to review statistical information with respect to Physician Assessment time	1) Develop a statistical report that will enable us to monitor the documentation of Physician Assessment date/time	Improve the percentage of Physician date/time documentation in Emergency/Urgent Care	
							2) Develop a strategy to improve documentation by physicians	2) Educate the physicians of the importance of providing complete documentation of date/time		
Patient-centred	Improve Patient Satisfaction	**From NRC Picker / HCAPHS:** "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes")	83.10%	83.10%	Maintain or improve current performance, while performance is greater than provincial average these are critical indicators that require ongoing attention, monitoring and follow up	3	Continue to improve continuity of care and transition	1) Education to physicians and nursing staff regarding results of NRC Picker and identified areas for improvement	Continue to improve the acute care experience by engaging patients and improving the patient experience	Data based on In-patient only
		From NRC Picker: "Overall, how would you rate the care and services you received at the hospital?" (add together percent of those who responded "Excellent, Very Good and Good")	97.80%	97.80%		3	Continue to improve emotional support to patients.	2) Trial random follow up call to patients within the first days of discharge regarding their recovery and to provide feedback on their experience while in hospital		
							Continue to encourage involvement of family in the patient care experience	3) Review of current discharge information provided and established an improved process to ensure patients/families are receiving necessary information and support while in hospital, and to home		
		In-house survey (if available): provide the percent response to a summary question such as the "Willingness of patients to recommend the hospital to friends or family" (Please list the question and the range of possible responses when you return the QIP)	N/A	N/A						
	Patient Relations	**Effective Service Recovery:** Development of a review process for patient oriented service recovery	N/A	100.00%	A complaints review process, especially concerns about quality of care, can enhance patients satisfaction and understanding of their medical care and treatment	1	Institute a more comprehensive review process for patient-oriented complaint-handling, or "Service Recovery". Revise current system for documenting patient complaint/concerns	Retrospective audit to determine levels of complaints/complexity and develop a measurement tool for resolution time. Establish a working group to develop a review process for patient oriented service recovery	To fully implement a comprehensive review process for patient -oriented complaint handling, or "Service Recovery" and revise current system for documenting patient complaint/concerns	

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	Employee Satisfaction	**Employee Satisfaction:** Assess key elements of our work environment that impact employee engagement	N/A	100%	Understand and improve employee satisfaction, morale and overall levels of performance	2	Measure commitment of employees to the organization and characteristics of the work environment that influence commitment	Implement the NRC Picker's employee experience measurement tool	To fully implement NRC Picker's employee experience measurement tool and obtain baseline indicator for proceeding fiscal year	
Integrated	Reduce unnecessary time spent in acute care	**Percentage ALC days:** Total number of inpatient days designated as ALC, divided by the total number of inpatient days. Q2 2011/12, DAD, CIHI	15%	13.60%	LHIN defined target from H-SAA contract schedule	1	Establish a working group to identify the root cause and promote efficiencies. Retrospective audit of ALC/CCC charts to review appropriateness and determine service requirements	Continued monitoring of ALC days and length of stay on a monthly basis	To reduce ALC days and lengths of stay	Current performance Q3 YTD
	Reduce unnecessary hospital readmission	**Readmission within 30 days for selected CMGs to any facility:** The number of patients with specified CMGs readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions - Q1 2011/12, DAD, CIHI	N/A	N/A						